SECTION 9

Post-acute care

Skilled nursing facilities
Home health services

Chart 9-1. The number of post-acute care providers generally continues to grow

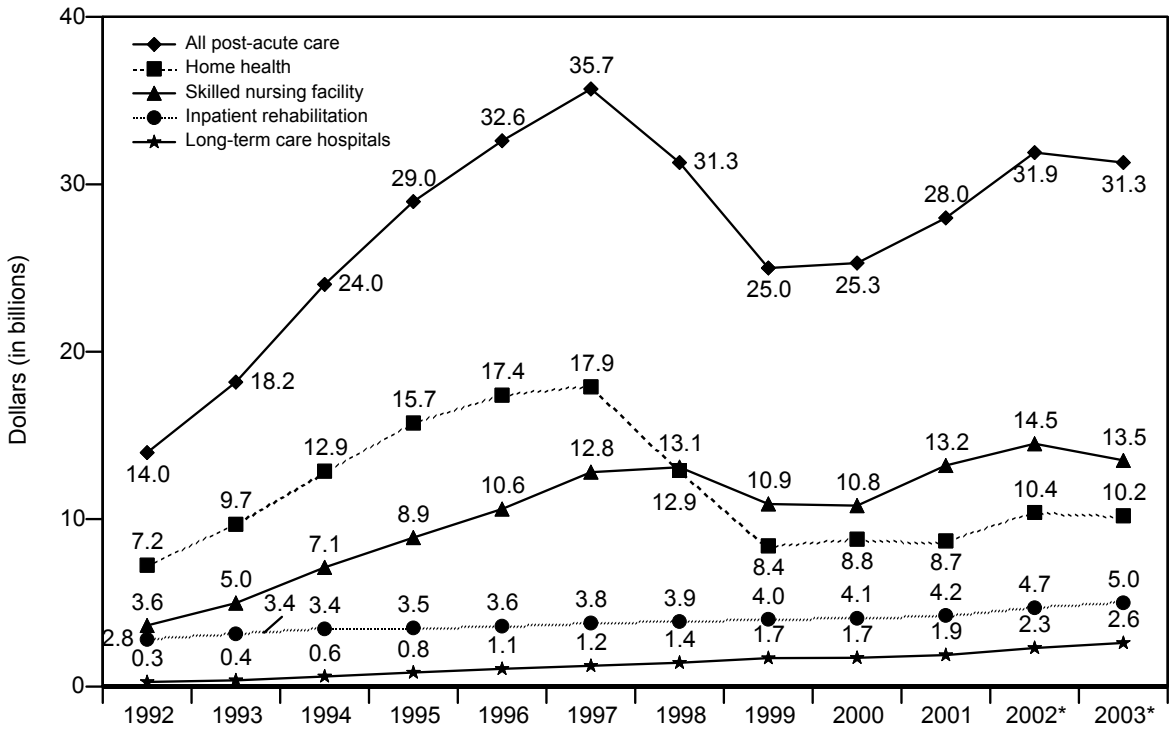
	1992	1994	1996	1998	2000	2002	2004
Skilled nursing facilities*	12,303	13,945	14,548	16,079	16,275	15,089	15,784
Home health agencies	6,447	8,003	9,808	9,284	7,317	6,888	7,148
Inpatient rehabilitation	907	1,001	1,031	1,078	1,102	1,181	1,206
Long-term care hospitals	97	146	183	209	240	286	307

Note: * Includes swing bed hospitals.

Source: Provider of service file from CMS.

- The number of post-acute care providers increased across all settings from 1992 to 2004.
- The number of skilled nursing facilities has declined since 2000 despite an increase from 2002-2004.
- The number of home health agencies increased by 50 percent from 1992 to their peak in 1996 and then dropped back to 1992 levels. This may be due to many factors including: the interim payment system, increased program integrity scrutiny, surety bond requirements, and other factors. The number has begun to increase again in the most recent period.
- Inpatient rehabilitation facilities increased by one-third from 1992 to 2004.
- The number of long-term care hospitals tripled from 1992 to 2004.
- More information on post-acute care can be found in Chapter 5 of the MedPAC June 2003 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June03_Ch5.pdf and Chapter 5 of the MedPAC June 2004 Report to Congress at http://www.medpac.gov/publications/congressional_reports/June04_ch5.pdf.

Chart 9-2. Medicare spending for post-acute care, by setting, 1992–2003



Note: Dollars are program spending figures and do not include beneficiary copayments.
*Spending for 2002 and 2003 are estimated.

Source: CMS, Office of the Actuary, 2003.

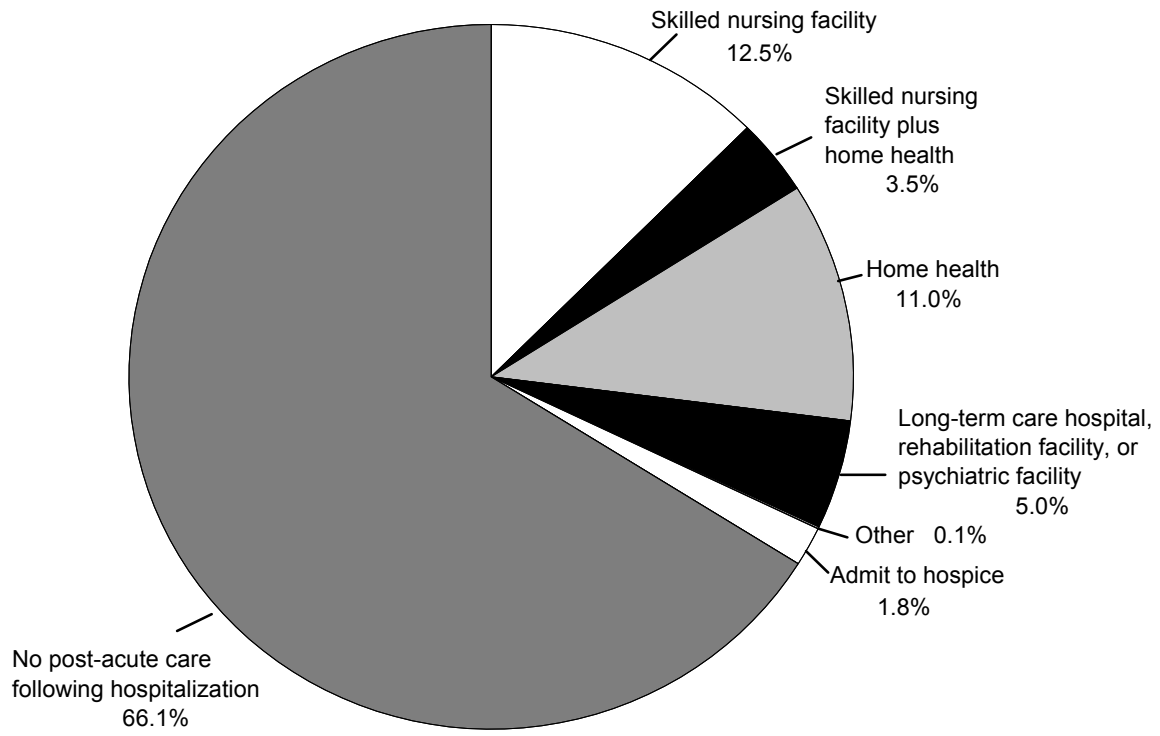
- Total spending for post-acute care increased rapidly at 21 percent per year from 1992 to 1997. During this period, spending for long-term care hospitals grew the fastest—at 35 percent per year—while spending for skilled nursing facility care increased at 29 percent per year, home health care increased at 20 percent per year, and inpatient rehabilitation increased at 6 percent per year.

- Total spending for post-acute care decreased between 1997 and 2000—by almost 30 percent—due largely to a 50 percent decrease in spending for home health services. Additional reasons include: The interim payment system, increased program integrity scrutiny, and other factors. For 2003, CMS estimated that total spending for post-acute care is at about 1995 levels.

- Post-acute care currently makes up about 11 percent of Medicare's total spending.

- More information can be found in Chapter 5 of the MedPAC June 2004 Report to the Congress, and Chapters 2C and 2D of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_Ch5.pdf and http://www.medpac.gov/publications/congressional_reports/Mar04_Ch2.pdf.

Chart 9-3. About one-third of hospital patients go on to use post-acute care

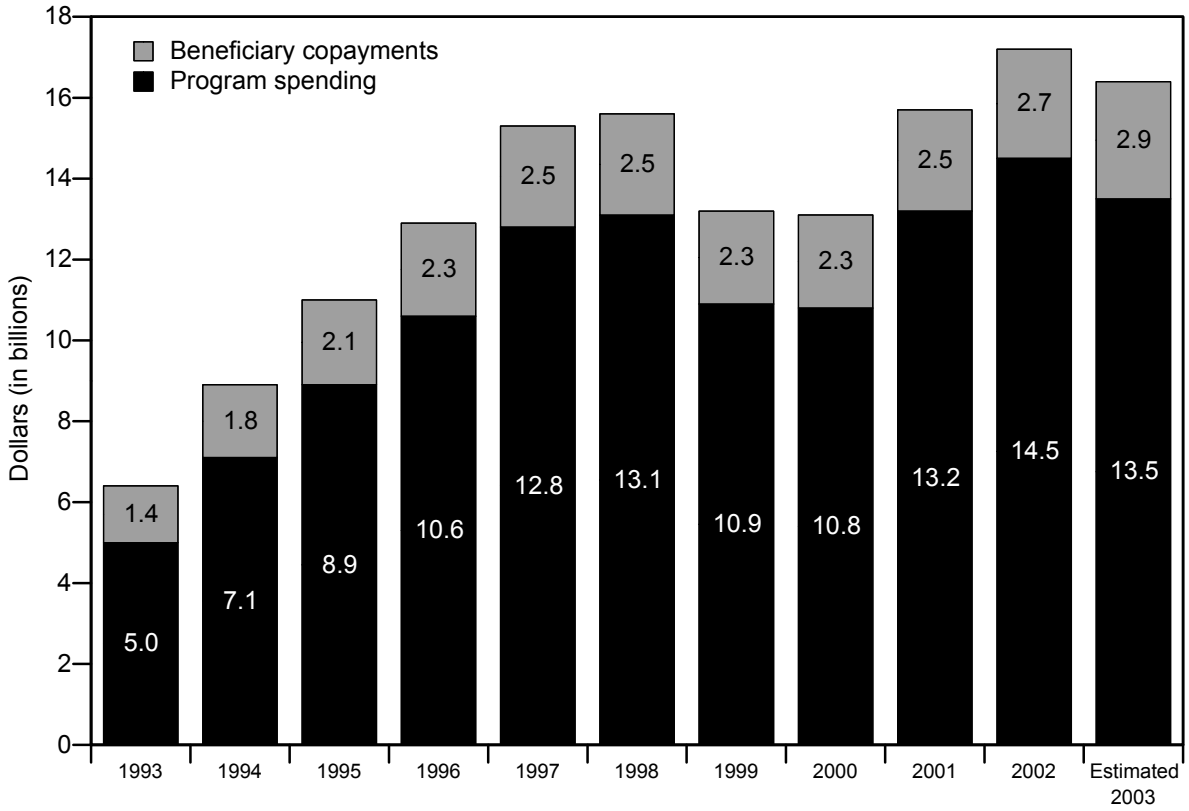


Note: Long–term care hospital, rehabilitation facility, or psychiatric facility includes beneficiaries who used other post–acute settings following their use of these settings. Other includes all other "mixed" episodes, e.g. home health followed by skilled nursing facility.

Source: Medicare beneficiaries' use of post–acute care 1996 compared to 2001. Report submitted to MedPAC by Christopher Hogan, Direct Research, May 12, 2004.

- The most common single post-acute care destination for beneficiaries discharged from acute inpatient care hospitals is a skilled nursing facility.
- Though some episodes are complicated and involve multiple settings, the most common episode includes only one post-acute setting.

Chart 9-4. Medicare spending for skilled nursing facility services generally increased over the decade 1993–2003



Note: Spending is for Part A services.

Source: CMS, Office of the Actuary, 2004.

- Total Medicare spending on skilled nursing facility (SNF) services grew rapidly (averaging 19 percent per year) from fiscal year 1993 through fiscal year 1998.

- In fiscal year 1999, immediately following the implementation of the SNF prospective payment system, total Medicare spending on SNF services fell from $15.6 billion to $13.2 billion. Prior to fiscal year 1998, Medicare paid SNFs based on their costs, subject to some limits.

- A number of factors contributed to the increase in total Medicare spending for SNF services from fiscal year 2000 to fiscal year 2002, including increases in the use of SNF services and increases in payment rates over the period. Payment rate increases occurred both because of annual updates and because of temporary payment add-ons mandated in the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000. Total SNF expenditures increased from $13 billion in 2000 to $17 billion in 2002.

- The decrease in total spending (about $800 million) estimated for fiscal year 2003 is due mostly to the expiration of two temporary payment add-ons at the end of fiscal year 2002.

Chart 9-5. Medicare skilled nursing facility use has remained relatively stable between 1997 and 2001

Year	Admissions		Days	
	Number (thousands)	Per 1,000 enrollees	Number (millions)	Per admission
1997	1,890	49	47.2	25.0
1998	1,885	49	44.5	23.6
1999	1,796	46	42.4	23.6
2000	1,824	46	43.8	24.0
2001	1,950	49	47.9	24.6
Average annual increase	0.8%	0.0%	0.4%	–0.4%

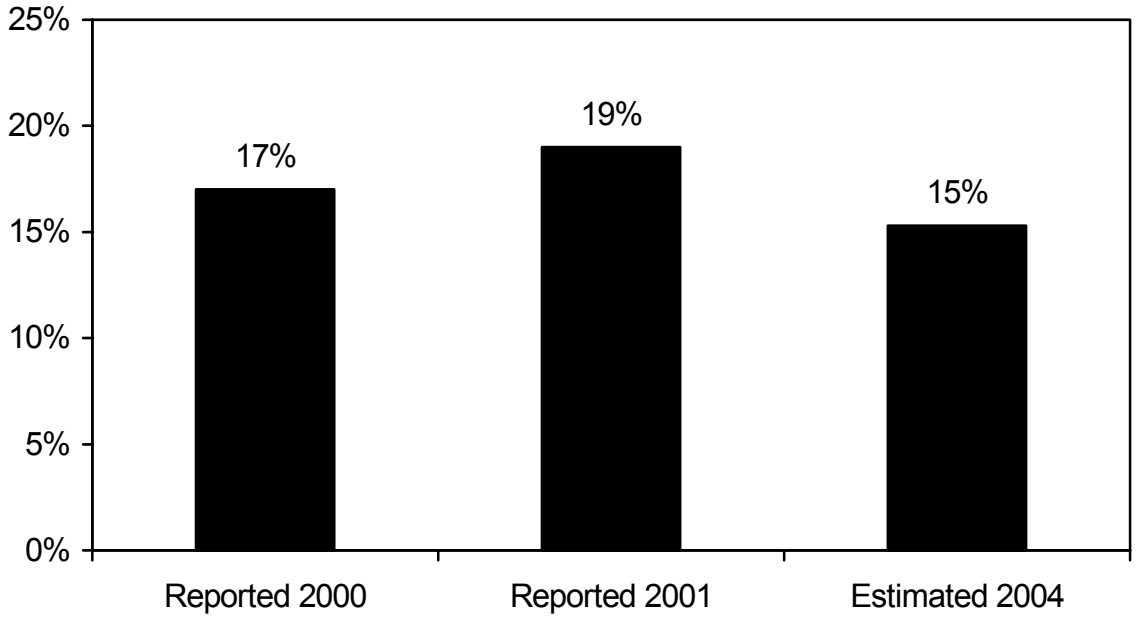
Note: Data include facilities in Puerto Rico, Virgin Islands, and "unknown." Data do not include swing bed units.

Source: CMS, Office of Research, Development, and Information, from Inpatient SNF MedPAR stay records.

- The number of Medicare admissions to a skilled nursing facility (SNF) remained relatively stable from 1997 to 2001. But admissions decreased by about 5 percent between 1997 and 1999 (the start of the SNF prospective payment system) then increased from 2000 to 2001. The number of Medicare-covered days in SNFs followed a similar pattern.

- The average length of stay in SNFs decreased by almost a day and a half from 1997 to 1998, but it increased again by one day between 1999 and 2001.

Chart 9-6. Medicare margins for freestanding skilled nursing facilities continue to be in the double digits, 2000, 2001, and estimated 2004



Note: Margin is calculated as revenue minus costs, divided by revenue.

Source: MedPAC analysis of Medicare cost report data from CMS.

- The Medicare margin for freestanding skilled nursing facilities (SNFs) increased 2 percentage points between fiscal year 2000 and fiscal year 2001. The primary reason for this increase was the introduction of a 16.66 percent add-on to the nursing component of SNFs' base payment rate in April 2001, mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement & Protection Act of 2000.

- Additional information on Medicare margins for skilled nursing facilities can be found in Chapter 3C of the MedPAC March 2004 Report to the Congress, Chapter 2C of the MedPAC March 2003 Report to the Congress, and Chapter 2D of the MedPAC March 2002 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/mar04_CH3C.pdf; http://www.medpac.gov/publications/congressional_reports/Mar03_Ch2C.pdf; http://www.medpac.gov/publications/congressional_reports/Mar02_Ch2D.pdf.

- The Medicare margin in fiscal year 2004 is about 15.3 percent. This represents the combination of three changes in the payment rates since fiscal year 2001:

  - The expiration of two temporary payment add-ons at the end of fiscal year 2002.

  - An administration action resulting in a 3.26 percent increase in SNFs' fiscal year 2004 base rates to correct for errors in forecasting the SNF market basket index for fiscal years 2000 through 2003.

  - A full 3 percent update in these rates for fiscal year 2004.

Chart 9-7. The highest percentage of Medicare-covered SNF days were in "very high" and "high" rehabilitation RUG–III groups in 2001

RUG–III group	Percent of Medicare days
Rehabilitation	**75.3%**
Ultra high, 16–18 ADL	1.0
Ultra high, 9–15 ADL	3.7
Ultra high, 4–8 ADL	1.0
Very high, 16–18 ADL	2.3
Very high, 9–15 ADL	11.3
Very high, 4–8 ADL	4.2
High, 13–18 ADL	14.9
High, 8–12 ADL	13.7
High, 4–7 ADL	4.6
Medium, 15–18 ADL	5.6
Medium, 8–14 ADL	9.5
Medium, 4–7 ADL	3.0
Low, 14–18 ADL	0.2
Low, 4–13 ADL	0.3
Extensive services	**7.8**
7–18 ADL, 4–5 services	3.2
7–18 ADL, 2–3 services	4.4
7–18 ADL, 0–1 services	0.2
Special care	**7.1**
17–18 ADL	1.6
15–16 ADL	2.2
7–14 ADL	3.3
Clinically complex	**6.9**
17–18 ADL, depression	0.2
17–18 ADL, no depression	0.7
12–16 ADL, depression	0.6
12–16, no depression	2.2
4–11, depression	0.7
4–11, no depression	2.5
Nonskilled RUGs	**2.7**

Note: ADL (activity of daily living), RUG–III (resource utilization group, version III), SNF (skilled nursing facility).

Source: MedPAC analysis of Medicare data from CMS, 2001.

- Three-quarters of the 48 million Medicare-covered days in skilled nursing facilities (SNFs) were in rehabilitation RUG-III groups in 2001.
- Medicare-covered SNF days were concentrated in two of the "high" rehabilitation groups (14.9 percent and 13.7 percent) and in one of the "very high" rehabilitation groups (11.3 percent).
- Extensive service, special care, and clinically complex RUG-III groups each accounted for about 7 to 8 percent of Medicare-covered days.

Chart 9-8. Hospital-based SNF patients tended to be younger than freestanding SNF patients in fiscal year 2000

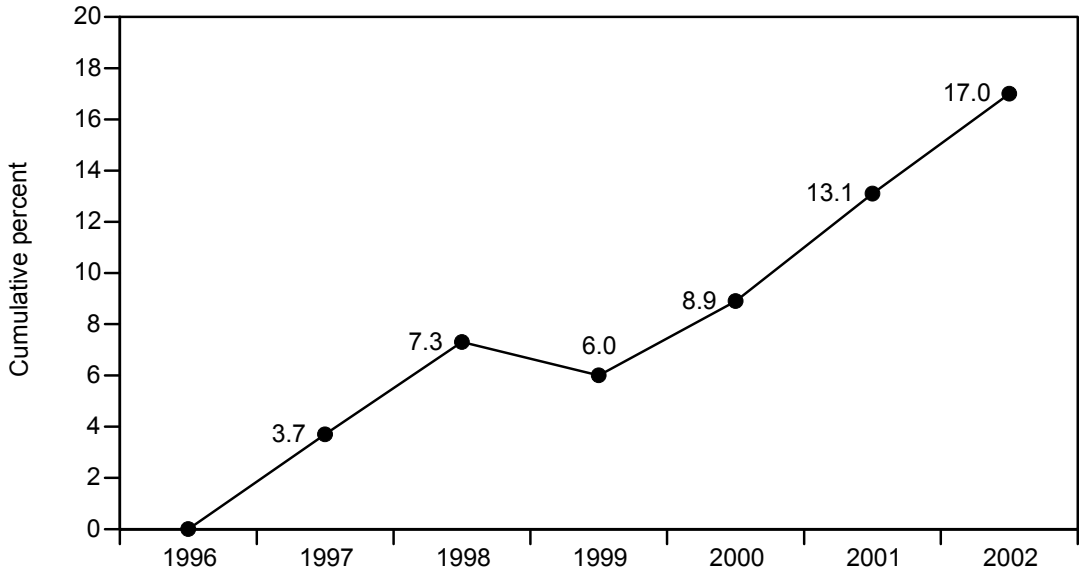
	Type of facility	
Characteristic	Freestanding	Hospital based
Female	66.3%	65.7%
Male	33.7	34.3
Age		
<65	4.9	6.2
65–74	16.9	23.6
75–84	40.7	42.4
85+	37.5	27.8
Medicare status		
Aged	94.4	93.2
Disabled	4.4	5.6
ESRD	1.2	1.3

Note: SNF (skilled nursing facility), ESRD (end-stage renal disease).

Source: MedPAC analysis of the Skilled Nursing Facility Stay File, 2000, from CMS.

- Hospital-based SNFs treat a higher proportion of younger patients (younger than 74 years old), while freestanding SNFs treat a higher proportion of patients 85 years old or older.
- Hospital-based SNFs treat a higher proportion of beneficiaries who qualify for Medicare because of a disability rather than freestanding SNFs.

Chart 9-9. Routine costs per day in freestanding SNFs increased 17 percent from 1996 to 2002

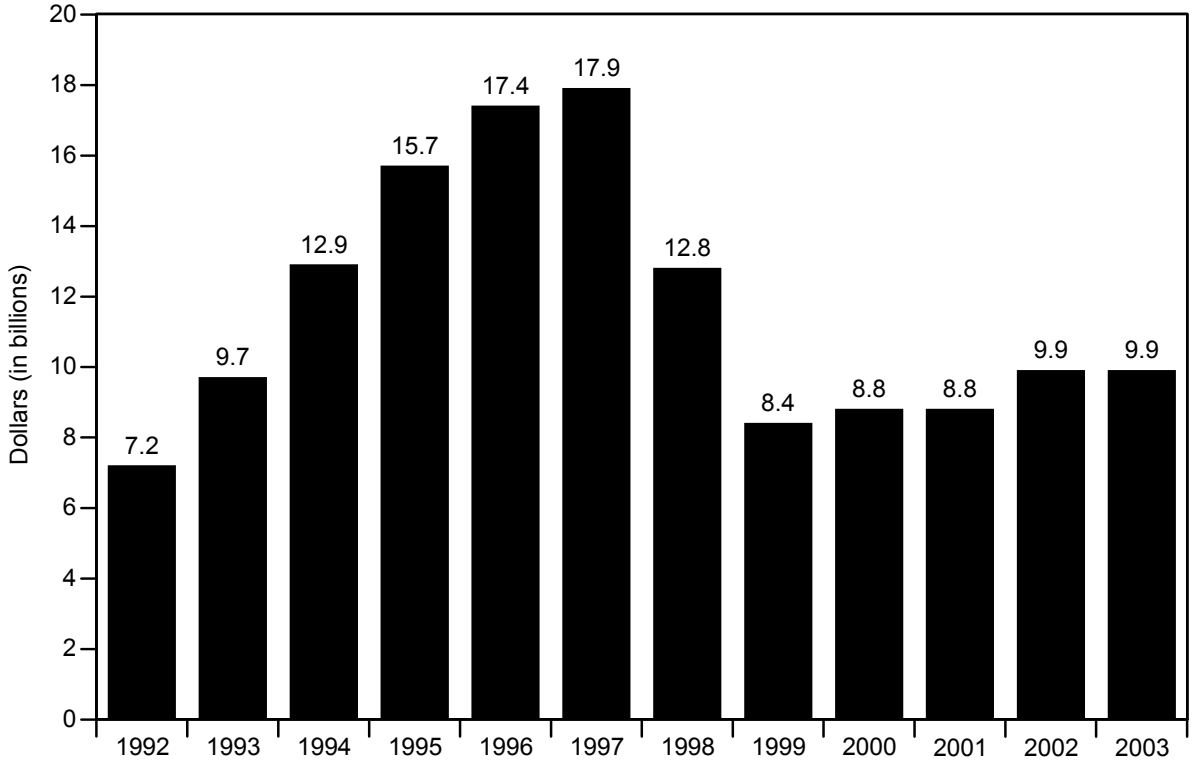


Note: SNF (skilled nursing facility). Routine cost growth per day was calculated from year to year among cohorts of freestanding SNF facilities that were submitting cost reports in both years.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Routine costs per day in freestanding skilled nursing facilities (SNFs) declined by 1.3 percent between fiscal year 1998 and fiscal year 1999, the first year of the SNF prospective payment system. In fiscal years 2000 through 2002, routine cost growth returned to its previous level of between 3 and 4 percent per year.

Chart 9-10. Spending for home health care, 1992–2003



Source: CMS, Office of the Actuary, 2004.

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period and enforcing the program's standards became more difficult.

- Spending began to fall in 1997, concurrent with the introduction of the interim payment system (IPS) based upon costs with limits, tighter eligibility, and increased scrutiny from the Office of Inspector General.

- In 2000, the prospective payment system replaced the IPS. At the same time, eligibility for the benefit was broadened slightly. Enforcement of the Medicare program's integrity standards continue at the regional home health intermediaries and survey and certification unites.

- More information on changes in home health spending can be found on the CMS website, available at http://www.cms.hhs.gov/review/current.asp.

Chart 9-11. Medicare home health care use, 1999–2000

Year	People served		Visits	
	Number (thousands)	Per 1,000 enrollees	Number (thousands)	Per person served
1992	2,506.2	70	132,220	53
1993	2,874.1	79	164,234	57
1994	3,179.2	93	208,621	66
1995	3,469.4	102	249,394	72
1996	3,599.7	107	264,798	74
1997	3,557.5	108	258,168	73
1998	3,061.6	95	155,407	51
1999	2,719.7	85	113,439	42
2000	2,461.2	75	90,566	37

Source: CMS, Office of the Actuary, December 2002.

- In the early 1990s, the rapid growth in home health use was a concern to policymakers. Between 1992 and 1996, the number of beneficiaries using home health care increased by more than one million. The total volume of home health was expanding rapidly as the number of visits per user increased along with the number of users.

- In the mid-1990s, the Congress required home health agencies to begin the transition to a prospective payment system, CMS clarified the standards of eligibility for the home health benefit, and the Office of Inspector General increased its scrutiny of home health. Between 1997 and 2000, the number of users fell by one million.

- Many measures of home health use are available at http://www.cms.hhs.gov/providers/hha.

Chart 9-12. Mix of home health visits changed after the prospective payment system started

	Pre-PPS			Post-PPS	
Type of visit	1997	1998	1999	2001	2002
Therapy	9%	11%	15%	25%	26%
Home health aide	49	42	35	24	23
Skilled nurse	41	45	48	50	51

Note: PPS (prospective payment system). The prospective payment system began in October 2000. Columns do not sum to 100 percent because data were not available for all visit types.

Source: Pre-PPS CMS analysis of the National Claims History file; post-PPS MedPAC analysis of 5 percent Standard Analytic File.

- The mix of visits (therapy, aide, or skilled visits as a percent of total visits provided during an episode) has shifted toward therapy (physical therapy, occupational therapy, and speech pathology) and away from home health aide services.
- An episode of home health care includes all of the visits and routine supplies that beneficiaries receive over a 60-day period. Beneficiaries can continue to receive episodes of home health care as long as they remain eligible for the benefit.
- The types and quantity of home health care services that beneficiaries receive are changing. In 1997, before the PPS, the average number of visits per episode was 36. By 2002, that had fallen to 21 visits. The average length of stay fell from 106 days in 1997 to 56 days in 2002.
- Information about the use of home health services after the PPS can be found on the official Medicare website, available at http://www.medicare.gov.

Chart 9-13. Freestanding home health agency Medicare margin, by type of agency, 2001, and estimated 2004

Type of agency	2001	2004
All agencies	16.2	16.8
Location of agency		
Urban	16.0	16.9
Rural	17.0	16.3
Caseload		
Urban	16.2	17.3
Mixed	15.3	15.1
Rural	18.7	17.8
Type of control		
Voluntary	15.0	15.6
Private	17.4	18.0
Government	10.7	11.3
Volume		
Very small (20th percentile)	11.4	12.1
Small (20th–40th)	15.0	15.6
Medium (40th–60th)	14.8	15.4
Large (60th–80th)	17.9	18.5
Very large (80th)	16.3	16.9

Note: Margins are the difference between Medicare's payments and costs, divided by payments.

Source: MedPAC analysis of Medicare Cost Report file from CMS.

- In 2001, 80 percent of agencies had positive margins. These estimated margins indicate that Medicare's payments are well above the costs of providing services to Medicare beneficiaries, for both rural and urban home health agencies (HHAs).

- These margins are for freestanding HHAs, which composed two-thirds of all HHAs in 2001. Home health agencies are also based in hospitals.

- More information on the adequacy of home health payments can be found in Chapter 3D of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3D.pdf.

Web links. Post-acute care

- Chapter 5 of the MedPAC June 2003 Report to the Congress provides information on post-acute care.

  http://www.medpac.gov/publications/congressional_reports/June03_Ch5.pdf

Skilled nursing facilities

- Chapter 3C of the MedPAC March 2004 Report to the Congress, Chapter 2C of the MedPAC March 2003 Report to the Congress, and Chapter 2D of the MedPAC March 2002 Report to the Congress provide information on Medicare margins for skilled nursing facilities.

  http://www.medpac.gov/publications/congressional_reports/June03_Ch5.pdf
  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch2C.pdf
  http://www.medpac.gov/publications/congressional_reports/Mar02_Ch2D.pdf

- The official Medicare website provides information on the prospective payment system and other related issues.

  http://www.cms.hhs.gov/providers/snfpps

Home health services

- Chapter 3D of the MedPAC March 2004 Report to the Congress provides information on home health services.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3D.pdf

- The official Medicare website provides information on the quality of home health care, and additional information on new policies, statistics, and research.

  http://www.cms.hhs.gov/providers/hha

Rehabilitation hospitals and units

- CMS provides information on the inpatient rehabilitation facility prospective payment system.

  http://cms.hhs.gov/providers/irfpps

Long-term care hospitals

- Chapter 5 of the MedPAC June 2004 Report to the Congress provides information on long-term care hospitals.

  http://www.medpac.gov/publications/congressional_reports/June04_ch5.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

  http://cms.hhs.gov/providers/longterm